7/16/2008

Indiana Access To Recovery (ATR) – Client Choice Form

INATR – 001 - Allen

I _____, understand that the Indiana Access to Recovery is a
(Enter Client's Name)
voluntary program and that my participation in the program is because I want to recover from my addictions.

I understand that there are a number of providers qualified to provide any service that I may require during my participation in the ATR program.

I also understand that I may choose the providers that provide services to me while I participate in the program.

I understand that the following providers are ready to provide Indiana ATR clients with recovery consultation.

AIDS Task Force		Center for Behavioral Health	
260-744-1144	260-745-0978	260-420-6010	260-420-9020
Phone Number	Fax Number	Phone Number	Fax Number

From the above list I have selected _____ to provide this service.
(Enter Name of Care Coordination Agency)

No one has exerted pressure on me to select this particular provider and I am confident that this provider is best suited to meet my needs for recovery consultation

I understand that if I find that this provider does not meet my needs, I may select another provider to replace this provider at any time.

I understand that _____ may not be willing or have the ability to
(Enter Name of Care Coordination Agency)
provide recovery consultation to me, in which case I will need to select a different provider.

I understand that the Recovery Consultant will need to contact me.
I authorize my chosen Recovery Consultant to contact me by contacting me at the following:

Address: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

I authorize the referral agency to release my information to help the Recovery Consultant contact me:

Referral Agency: _____

Referral Agent: _____

_____ _____/_____/_____
Signature Date